FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: SOUTH SHORE NSG & REHAB CTR

Address: 2649 E. 75TH STREET (Number) CHICAGO (City) 60649 (Zip Code)

County: COOK

Telephone Number: (773) 356-9300 **Fax #** (773) 356-9384

IDPA ID Number: 364209295001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	71,537	4,497	4,595	80,629	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,537	4,497	4,595	80,629	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.04%

D. How many bed-hold days during this year were paid by Public Aid?
2359 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/28/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/28/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 4142

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	326,176	37,776	20,760	384,712		384,712	(5,347)	379,365			1
2	Food Purchase		286,814		286,814	(7,490)	279,324	1,654	280,979			2
3	Housekeeping	211,591	50,177		261,768		261,768	2,507	264,275			3
4	Laundry	92,580	27,621		120,201		120,201		120,201			4
5	Heat and Other Utilities			241,670	241,670		241,670	3,322	244,992			5
6	Maintenance	69,396		275,643	345,039		345,039	16,157	361,196			6
7	Other (specify):*							2,842	2,842			7
8	TOTAL General Services	699,743	402,388	538,073	1,640,204	(7,490)	1,632,714	21,136	1,653,850			8
	B. Health Care and Programs											
9	Medical Director			8,750	8,750		8,750		8,750			9
10	Nursing and Medical Records	2,537,341	79,490	12,725	2,629,556		2,629,556	18,597	2,648,153			10
10a	Therapy	79,958	248	7,459	87,665		87,665	3,373	91,038			10a
11	Activities	148,236	10,357	6,558	165,151		165,151	(1,403)	163,748			11
12	Social Services	86,962		993	87,955		87,955	1,734	89,689			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							6,443	6,443			15
16	TOTAL Health Care and Programs	2,852,497	90,095	36,485	2,979,077		2,979,077	28,744	3,007,821			16
	C. General Administration											
17	Administrative	38,199		291,101	329,300		329,300	60,520	389,820			17
18	Directors Fees											18
19	Professional Services			402,502	402,502	(3,000)	399,502	(342,491)	57,011			19
20	Dues, Fees, Subscriptions & Promotions			75,313	75,313		75,313	(44,119)	31,194			20
21	Clerical & General Office Expenses	164,565	24,807	476,204	665,576		665,576	(265,394)	400,182			21
22	Employee Benefits & Payroll Taxes			685,782	685,782	7,490	693,272	(18,091)	675,181			22
23	Inservice Training & Education			191	191		191		191			23
24	Travel and Seminar			2,465	2,465		2,465	1,756	4,221			24
25	Other Admin. Staff Transportation			1,425	1,425		1,425	328	1,753			25
26	Insurance-Prop.Liab.Malpractice			304,944	304,944		304,944	1,701	306,645			26
27	Other (specify):*							35,365	35,365			27
28	TOTAL General Administration	202,764	24,807	2,239,927	2,467,498	4,490	2,471,988	(570,425)	1,901,563			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,755,004	517,290	2,814,485	7,086,779	(3,000)	7,083,779	(520,545)	6,563,234			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR #0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,113	28,113		28,113	433,363	461,476			30
31	Amortization of Pre-Op. & Org.			3,012	3,012		3,012	15,373	18,385			31
32	Interest			6,329	6,329		6,329	1,059,104	1,065,433			32
33	Real Estate Taxes			402,268	402,268	3,000	405,268	(78,735)	326,533			33
34	Rent-Facility & Grounds			1,357,800	1,357,800		1,357,800	(1,351,185)	6,615			34
35	Rent-Equipment & Vehicles			5,828	5,828		5,828	4,994	10,822			35
36	Other (specify):*											36
37	TOTAL Ownership			1,803,350	1,803,350	3,000	1,806,350	82,914	1,889,264			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		225,587	168,387	393,974		393,974	(10,425)	383,549			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,400	131,400		131,400		131,400			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		225,587	299,787	525,374		525,374	(10,425)	514,949			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,755,004	742,877	4,917,622	9,415,503		9,415,503	(448,056)	8,967,447			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,324)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,045	30		9
10	Interest and Other Investment Income	(35,486)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(158)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(401,000)	21		24
25	Fund Raising, Advertising and Promotional	(20,221)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,100)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(155,654)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (611,898)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	163,842		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 163,842		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (448,056)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SOUTH SHORE NSG & REHAB CTR

ID# 0042119

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collection Expense	$ (5,522)	21	1
2	Bank Charges	(3,049)	21	2
3	Theft Loss	(1,176)	21	3
4	Bank Charges - Bldg Co	(25)	21	4
5	Trust Fees - Bldg Co	(300)	21	5
6	LLC Fees - Bldg Co	(200)	21	6
7	Jury Duty	(258)	10	7
8	Prior Period Real Estate Tax	(73,555)	33	8
9	Prior Period Voided Payroll Checks	(6,792)	10	9
10	Non-Care Depreciation (KFC Bldg)	(3,436)	30	10
11	Prior Year Legal Fees	(603)	19	11
12	Legal Fees from Care Centers	(10,968)	19	12
13	Management Fee - Bldg Co	(45,000)	17	13
14	Survey - Bldg Co	(350)	19	14
15	ICLTC - COPE	(4,420)	20	15
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			6,411	(8,760)		(2,998)						(5,347)	1
2	Food Purchase	(2,482)		(602)			4,739						1,654	2
3	Housekeeping			2,507									2,507	3
4	Laundry													4
5	Heat and Other Utilities			3,322									3,322	5
6	Maintenance			18,404	(2,248)		1						16,157	6
7	Other (specify):*			2,598			244						2,842	7
8	**TOTAL General Services**	(2,482)		32,640	(11,008)		1,986						21,136	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,050)		37,557	(7,058)		44	(4,896)					18,597	10
10a	Therapy			7,487	(4,114)								3,373	10a
11	Activities			2,899	(4,302)								(1,403)	11
12	Social Services			2,727	(993)								1,734	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			6,443									6,443	15
16	**TOTAL Health Care and Programs**	(7,050)		57,113	(16,467)		44	(4,896)					28,744	16
	C. General Administration													
17	Administrative	(45,000)	45,000	60,404	(74,906)	74,906	116						60,520	17
18	Directors Fees													18
19	Professional Services	(11,921)	(296)	8,854	(339,150)		22						(342,491)	19
20	Fees, Subscriptions & Promotions	(24,641)		2,412	(21,900)		10						(44,119)	20
21	Clerical & General Office Expenses	(412,372)	525	173,235	(26,986)		204						(265,394)	21
22	Employee Benefits & Payroll Taxes				(18,091)								(18,091)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,755			1						1,756	24
25	Other Admin. Staff Transportation			94			234						328	25
26	Insurance-Prop.Liab.Malpractice			1,701									1,701	26
27	Other (specify):*			26,260		9,105							35,365	27
28	**TOTAL General Administration**	(493,934)	45,229	274,715	(481,033)	84,011	587						(570,425)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(503,466)	45,229	364,468	(508,507)	84,011	2,617	(4,896)					(520,545)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	609	419,748	13,006									433,363	30
31	Amortization of Pre-Op. & Org.		15,373										15,373	31
32	Interest	(35,486)	1,080,974	13,612			4						1,059,104	32
33	Real Estate Taxes	(73,555)	(10,000)	4,820									(78,735)	33
34	Rent-Facility & Grounds		(1,357,800)	6,615									(1,351,185)	34
35	Rent-Equipment & Vehicles			4,982			12						4,994	35
36	Other (specify):*													36
37	TOTAL Ownership	(108,432)	148,295	43,035			16						82,914	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,927)	(5,498)					(10,425)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(4,927)	(5,498)					(10,425)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(611,898)	193,524	407,503	(508,507)	84,011	(2,294)	(10,394)					(448,056)	45

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				SOUTH SHORE PROPERTIES, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,357,800	SOUTH SHORE PROPERTIES, LLC	100.00%	$	$ (1,357,800)	1
2	V	33	MISC INC. - RE TAX - KFC		SOUTH SHORE PROPERTIES, LLC	100.00%	(10,000)	(10,000)	2
3	V	32	INTEREST EXPENSE		SOUTH SHORE PROPERTIES, LLC	100.00%	1,080,974	1,080,974	3
4	V	21	BANK CHARGES		SOUTH SHORE PROPERTIES, LLC	100.00%	25	25	4
5	V	21	TRUST FEES		SOUTH SHORE PROPERTIES, LLC	100.00%	300	300	5
6	V	31	AMORTIZATION		SOUTH SHORE PROPERTIES, LLC	100.00%	15,373	15,373	6
7	V	30	DEPRECIATION		SOUTH SHORE PROPERTIES, LLC	100.00%	419,748	419,748	7
8	V	21	LLC FEE		SOUTH SHORE PROPERTIES, LLC	100.00%	200	200	8
9	V	19	MISC INC. - LEGAL FEE		SOUTH SHORE PROPERTIES, LLC	100.00%	(646)	(646)	9
10	V	17	MANAGEMENT FEE		SOUTH SHORE PROPERTIES, LLC	100.00%	45,000	45,000	10
11	V	19	SURVEY		SOUTH SHORE PROPERTIES, LLC	100.00%	350	350	11
12	V								12
13	V								13
14	Total			$ 1,357,800			$ 1,551,324	$ * 193,524	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 6,411	$ 6,411	15
16	V	2	FOOD		CARE CENTERS, INC.	100.00%	(602)	(602)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.	100.00%	2,507	2,507	17
18	V	5	UTILITIES		CARE CENTERS, INC.	100.00%	3,322	3,322	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.	100.00%	18,404	18,404	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.	100.00%	2,598	2,598	20
21	V	10	NURSING		CARE CENTERS, INC.	100.00%	37,557	37,557	21
22	V	10A	THERAPY		CARE CENTERS, INC.	100.00%	7,487	7,487	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.	100.00%	2,899	2,899	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.	100.00%	2,727	2,727	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.	100.00%	6,443	6,443	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	60,404	60,404	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.	100.00%	8,854	8,854	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.	100.00%	2,412	2,412	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.	100.00%	173,235	173,235	29
30	V	24	SEMINARS		CARE CENTERS, INC.	100.00%	1,755	1,755	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.	100.00%	94	94	31
32	V	26	INSURANCE		CARE CENTERS, INC.	100.00%	1,701	1,701	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.	100.00%	26,260	26,260	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.	100.00%	13,006	13,006	34
35	V	32	INTEREST		CARE CENTERS, INC.	100.00%	13,612	13,612	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.	100.00%	4,820	4,820	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.	100.00%	6,615	6,615	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.	100.00%	4,982	4,982	38
39	Total			$			$ 407,503	$ * 407,503	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,760	CARE CENTERS, INC.	100.00%	$	$ (8,760)	15
16	V	19	ACCOUNTING	15,000	CARE CENTERS, INC.	100.00%		(15,000)	16
17	V	19	ANCIL ADMIN FEE	28,800	CARE CENTERS, INC.	100.00%		(28,800)	17
18	V	19	BOOKEEPING	48,960	CARE CENTERS, INC.	100.00%		(48,960)	18
19	V	19	DATA PROCESSING	8,640	CARE CENTERS, INC.	100.00%		(8,640)	19
20	V	19	LEGAL	21,900	CARE CENTERS, INC.	100.00%		(21,900)	20
21	V	19	MANAGEMENT FEE	201,600	CARE CENTERS, INC.	100.00%		(201,600)	21
22	V	19	PROFESSIONAL FEES	14,250	CARE CENTERS, INC.	100.00%		(14,250)	22
23	V	20	ADVERTISING	21,900	CARE CENTERS, INC.	100.00%		(21,900)	23
24	V	25	REBILL BUS		CARE CENTERS, INC.	100.00%			24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	18,091	CARE CENTERS, INC.	100.00%		(18,091)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.	100.00%			27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.	100.00%			28
29	V	6	REBILL. PAYROLL MAINT.	2,248	CARE CENTERS, INC.	100.00%		(2,248)	29
30	V	10	REBILL. PAYROLL NURSING	7,058	CARE CENTERS, INC.	100.00%		(7,058)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,114	CARE CENTERS, INC.	100.00%		(4,114)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	4,302	CARE CENTERS, INC.	100.00%		(4,302)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	993	CARE CENTERS, INC.	100.00%		(993)	33
34	V	17	REBILL. PAYROLL ADMIN.	74,906	CARE CENTERS, INC.	100.00%		(74,906)	34
35	V	21	REBILL. PAYROLL CLERICAL	26,986	CARE CENTERS, INC.	100.00%		(26,986)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 508,507			$	$ * (508,507)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$	$	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.	100.00%			16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	74,906	74,906	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.	100.00%	9,105	9,105	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 84,011	$ * 84,011	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,678	$ 2,678	15
16	V	2	FOOD		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	4,739	4,739	16
17	V	6	MAINTENANCE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	17
18	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	244	244	18
19	V	10	NURSING		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	44	44	19
20	V	17	ADMINISTRATIVE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	116	116	20
21	V	19	PROFESSIONAL FEES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	22	22	21
22	V	20	DUES, FEES, SUB.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	10	10	22
23	V	21	CLERICAL & GENERAL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	204	204	23
24	V	24	SEMINARS		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	24
25	V	25	TRAVEL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	234	234	25
26	V	32	INTEREST		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	4	4	26
27	V	35	RENT - EQUIPMENT & VEHICLES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	12	12	27
28	V	39	ANCILLARY ENTERAL SUPPLIES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	155	155	28
29	V	1	DIETARY SUPP	5,676	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(5,676)	29
30	V	39	ANCILLARY SUPP	5,082	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(5,082)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,758			$ 8,464	$ * (2,294)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 40,316	$ 40,316	15
16	V	39	MEDICAL SUPPLIES		XCEL MEDICAL SUPPLLY LLC	100.00%	45,267	45,267	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	45,212	XCEL MEDICAL SUPPLLY LLC	100.00%		(45,212)	19
20	V	39	MEDICAL SUPPLIES	50,765	XCEL MEDICAL SUPPLLY LLC	100.00%		(50,765)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 95,977			$ 85,583	$ * (10,394)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 96,532	$ 96,532	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	96,532	CCS EMPLOYEE BENEFIT GROUP	100.00%		(96,532)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,532			$ 96,532	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Aronin	Owner	Administrative	0.83%	see attached	2.65	5.30%	CCI salary	$ 4,609	17-7	1
2	Sandy Bokor	Relative	Administrative		see attached	1	2.00%	Mgmt Fees	12,000	17-3	2
3	Ron Abrams	Owner	Administrative	8.33%	see attached	1	2.86%	Mgmt Fees	12,000	17-3	3
4	Alan Abrams	Owner	Administrative	8.33%	see attached	1	2.86%	Mgmt Fees	12,000	17-3	4
5	Mark Steinberg	Relative	Administrative		see attached	2.65	5.30%	CCI salary	2,353	17-7	5
6	Eric Rothner	Relative	Administrative		see attached	2.6	3.61%	Mgmt Fees	180,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 222,962		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	80,629	$ 6,411	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		80,629	(602)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	80,629	2,507	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		80,629	3,322	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	80,629	18,404	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		80,629	2,598	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	80,629	37,557	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	80,629	7,487	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	80,629	2,899	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	80,629	2,727	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		80,629	6,443	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	80,629	60,404	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		80,629	8,854	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		80,629	2,412	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	80,629	173,235	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		80,629	1,755	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		80,629	94	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		80,629	1,701	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		80,629	26,260	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		80,629	13,006	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		80,629	13,612	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		80,629	4,820	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		80,629	6,615	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		80,629	4,982	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 407,503	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.
Street Address 150 FENCL LANE
City / State / Zip Code HILLSIDE, IL. 60162
Phone Number (708)449-9090
Fax Number (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		74,906	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			9,105	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 84,011	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	10,758	2,678	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		10,758	4,739	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		10,758	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		10,758	244	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		10,758	44	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		10,758	116	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		10,758	22	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		10,758	10	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		10,758	204	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		10,758	1	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		10,758	234	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		10,758	4	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		10,758	12	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		10,758	155	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 8,464	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 40,316	1
2	39	MEDICAL SUPPLIES	DIRECT ALLOCATION						45,267	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 85,583	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 96,532	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 96,532	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Corus Bank			MORTGAGE (BLDG CO.)			$	$ 9,796,163			$ 754,315	1
2	CIB Bank			MORTGAGE (BLDG CO.)				3,645,645			308,274	2
3												3
4												4
5												5
	Working Capital											
6	Daiwa Loan		X								6,329	6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,441,808			$ 1,068,918	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							244,379			(3,485)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 244,379			$ (3,485)	14
15	TOTALS (line 9+line14)						$	$ 13,686,187			$ 1,065,433	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Due to Related Parties						$	$ 244,379			$ 18,385	1
2	Interest Income										(35,486)	2
3	Allocation from Care Centers, Inc.										13,616	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 244,379			$ (3,485)	21

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 353,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 319,445	2
3. Under or (over) accrual (line 2 minus line 1).		$ (33,555)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 357,088	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 3,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 326,533	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	108,397	10
1999	266,137	11
2000	324,625	12

2001 accrual = $324,625 (2000 RE Taxes) x 1.1

Line 2: $324,625 + $4820 (alloc from CCI) - $10,000 (RE Tax income, page 6) = $319,445

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTH SHORE NSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See attached	Home Office Allocation	$ 66,986.83	$ 3,547.80
2.	21-30-200-008-0000	Long Term Care Property	$ 49,699.90	$ 49,699.90
3.	21-30-200-001-0000	Long Term Care Property	$ 265,290.43	$ 265,290.43
4.	21-30-200-002-0000	Long Term Care Property	$ 3,496.73	$ 3,496.73
5.	21-30-121-008-0000	Long Term Care Property	$ 4,224.37	$ 4,224.37
6.	21-30-121-009-0000	Long Term Care Property	$ 1,913.82	$ 1,913.82
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 391,612.08	$ 328,173.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 115,306
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 18,385
4. Dates Incurred: various

Nature of Costs: Financing Fees, Closing Cost, Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	101,000	1994	$ 352,000	1
2	Allocation from Care Centers			3,390	2
3	TOTALS	101,000		$ 355,390	3

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	$ 11,715,725	$ 309,634	35	$ 334,735	$ 25,101	$ 1,160,918	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		85,779	1,998		3,046	1,048	14,039	68
69	Financial Statement Depreciation			2,514			(2,514)		69
70	TOTAL (lines 4 thru 69)		$ 11,801,504	$ 314,146		$ 337,781	$ 23,635	$ 1,174,957	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,801,504	$ 314,146		$ 337,781	$ 23,635	$ 1,174,957	1
2	WINDOW CLEANING	1998	1,900		20	95	95	340	2
3	FIRE ALARM BOX	1998	1,988		20	99	99	355	3
4	TELE CABLING	1998	603		20	30	30	108	4
5	SIGNS	1998	1,000		20	50	50	171	5
6	CABLING	1998	508		20	25	25	85	6
7	SIGN LETTERING	1998	2,500		20	125	125	417	7
8	SECURITY SYSTEM	1998	3,500		20	175	175	583	8
9	SIGNS	1998	573		20	29	29	97	9
10	BALLASTS	1998	501		20	25	25	83	10
11	SECURITY SYSTEM	1998	3,786		20	189	189	614	11
12	ELECTRICAL	1998	710		20	36	36	117	12
13	PLUMBING	1998	837		20	42	42	133	13
14	SECURITY SYSTEM	1998	3,800		20	190	190	602	14
15	ADDL BLDG LEGAL FEES	1998	491		20	25	25	50	15
16	SIGN	1999	2,240		20	112	112	299	16
17	A/C UPGRADE	1999	3,800		20	190	190	507	17
18	WIRING	1999	13,000		20	650	650	1,408	18
19	HVAC RENOV	1999	1,796		20	90	90	188	19
20	ADDL BLDG LEGAL FEES	1999	1,953		20	98	98	196	20
21	BOILER RENOV	2000	967		20	48	48	96	21
22	TV WIRING	2000	18,268		20	913	913	1,750	22
23	CABLING	2000	952		20	48	48	88	23
24	PLUMBING RENOV	2000	894		20	45	45	79	24
25	WATER HEATER	2000	9,417		20	471	471	824	25
26	HVAC	2000	4,562		20	228	228	361	26
27	HVAC	2000	5,908		20	295	295	492	27
28	ELEVATOR PARTS	2000	558		20	28	28	40	28
29	HOT WATER HEATER	2001	3,980		20	199	199	199	29
30	FAN POWER BOX	2001	589		20	27	27	27	30
31	EXIT SIGN	2001	2,336		20	88	88	88	31
32	CHILLER BUNDLE	2001	2,020		20	67	67	67	32
33	SPRINKLER SYSTEM	2001	1,405		20	41	41	41	33
34	TOTAL (lines 1 thru 33)		$ 11,898,846	$ 314,146		$ 342,554	$ 28,408	$ 1,185,462	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,898,846	$ 314,146		$ 342,554	$ 28,408	$ 1,185,462	1
2	CYLLANDER ASSY	2001	2,394		20	50	50	50	2
3	BYPASS ON WATER HEAT	2001	2,146		20	36	36	36	3
4	BOILER	2001	4,000		20	50	50	50	4
5	TUBE SECTIONS	2001	6,074		20	76	76	76	5
6	BOILER REPAIR	2001	3,340		20	28	28	28	6
7	BOILER	2001	851		20	7	7	7	7
8	BOILER REPAIR	2001	10,192		20	85	85	85	8
9	POWER WC REPAIR	2001	575		20	5	5	5	9
10	TILES	2001	1,550		20	155	155	155	10
11	BOILER REPAIR	2001	1,676		20	70	70	70	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,931,644	$ 314,146		$ 343,116	$ 28,970	$ 1,186,024	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	CCI allocation			1996	$ 59,987	$ 1,538	35	$ 1,714	$ 176	$ 8,712	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers, Inc.			2001	171	22	20	4	(18)	4	9
10	Allocation from Care Centers, Inc.			2000	72	2	20	4	2	7	10
11	Allocation from Care Centers, Inc.			1999	1,074	28	20	54	26	155	11
12	Allocation from Care Centers, Inc.			1998	443	11	20	22	(11)	81	12
13	Allocation from Care Centers, Inc.			1997	6,292	111	20	347	236	2,029	13
14	Allocation from Care Centers, Inc.			1996	6,916	91	20	365	274	1,433	14
15	Allocation from Care Centers, Inc.			1997	730	169	20	31	(138)	103	15
16	Allocation from Care Centers, Inc.			1994		20	20		(20)		16
17	Allocation from Care Centers, Inc.			1993		6	20		(6)		17
18											18
19	Fence - South Shore Building Co.			1998	10,094	-	20	505	505	1,515	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 85,779	$ 1,998		$ 3,046	$ 1,026	$ 14,039	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,062,757	$ 136,069	$ 113,032	$ (23,037)	10	$ 409,574	71
72	Current Year Purchases	10,520	2,776	879	(1,897)	10	879	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,073,277	$ 138,845	$ 113,911	$ (24,934)		$ 410,453	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Center allocation		$ 29,007	$ 4,438	$ 4,447	$ 9	10	$ 14,311	76
77										77
78										78
79										79
80	TOTALS			$ 29,007	$ 4,438	$ 4,447	$ 9		$ 14,311	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,389,318	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 457,429	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 461,474	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,045	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,610,788	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	KFC Building - 1999	$ 134,000	$ 3,436	$ 10,165	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 134,000	$ 3,436	$ 10,165	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers, Inc.				6,615			5
6								6
7	TOTAL				$ 6,615 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 10,822 Description: Oxygen Concentrator $345; Copier $4546; Timeclock $937; allocation from Care Centers $4994
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 66,925	$		$ 66,925	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			25,003			25,003	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			76,459			76,459	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				107,599		107,599	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						117,988		117,988	13
14	TOTAL			$		$ 168,387	$ 225,587		$ 393,974	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,621	$ 16,540	1
2	Cash-Patient Deposits	69,521	69,521	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,799,259	2,799,259	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,084	129,084	6
7	Other Prepaid Expenses	2,667	2,667	7
8	Accounts Receivable (owners or related parties)	1,531,923	1,531,923	8
9	Other(specify): See supplemental schedule	50,690	50,690	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,592,765	$ 4,599,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		12,209,725	14
15	Leasehold Improvements, at Historical Cost	124,471	124,471	15
16	Equipment, at Historical Cost	140,539	1,019,494	16
17	Accumulated Depreciation (book methods)	(86,867)	(1,923,005)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	503	87,147	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 178,646	$ 11,869,832	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,771,411	$ 16,469,516	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 485,071	$ 485,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,912	67,912	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,307	193,307	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,462	21,462	31
32	Accrued Real Estate Taxes(Sch.IX-B)	357,088	357,088	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	16,532	16,532	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	49,020	1,133,500	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,190,392	$ 2,274,873	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		244,379	39
40	Mortgage Payable		13,441,808	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,686,187	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,190,392	$ 15,961,060	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,581,019	$ 508,456	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,771,411	$ 16,469,516	48

*(See instructions.)

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,479,729	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,479,730	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,281,789	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(180,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,101,289	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,581,019	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,520,718	1
2	Discounts and Allowances for all Levels	(1,032,607)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,488,111	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	831,586	6
7	Oxygen	39,095	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 870,681	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,324	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	116,708	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,583	19
20	Radiology and X-Ray	7,860	20
21	Other Medical Services	162,281	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 302,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35,486	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,486	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	258	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 258	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,697,292	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,640,204	31
32	Health Care	2,979,077	32
33	General Administration	2,467,498	33
	B. Capital Expense		
34	Ownership	1,803,350	34
	C. Ancillary Expense		
35	Special Cost Centers	393,974	35
36	Provider Participation Fee	131,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,415,503	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,281,789	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,281,789	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,768	2,008	$ 55,985	$ 27.88	1
2	Assistant Director of Nursing	2,430	2,699	62,068	23.00	2
3	Registered Nurses	13,666	14,817	307,153	20.73	3
4	Licensed Practical Nurses	51,101	54,958	984,482	17.91	4
5	Nurse Aides & Orderlies	120,270	132,338	1,076,604	8.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,397	7,149	79,958	11.18	8
9	Activity Director	2,008	2,317	34,652	14.96	9
10	Activity Assistants	14,967	16,167	113,584	7.03	10
11	Social Service Workers	8,455	9,300	86,962	9.35	11
12	Dietician					12
13	Food Service Supervisor	5,466	6,205	72,952	11.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,005	35,708	253,224	7.09	15
16	Dishwashers					16
17	Maintenance Workers	5,983	6,356	69,396	10.92	17
18	Housekeepers	29,949	31,451	211,591	6.73	18
19	Laundry	12,718	13,517	92,580	6.85	19
20	Administrator					20
21	Assistant Administrator	2,032	2,415	38,199	15.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,317	16,116	164,565	10.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,420	5,975	51,049	8.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,952	359,496	$ 3,755,004 *	$ 10.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	300	$ 12,000	01-03	35
36	Medical Director	monthly	8,750	09-03	36
37	Medical Records Consultant	monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,635	10-03	39
40	Physical Therapy Consultant	31	1,550	10a-03	40
41	Occupational Therapy Consultant	36	1,795	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,256	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI PAYROLL (SEE ATTACHED)		25,227	VARIOUS	47
48					48
49	TOTAL (lines 35 - 48)	418	$ 57,245		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Williams	Asst. Administator	0	$ 38,199
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 38,199

B. Administrative - Other

Description	Amount
Administrator Salary	$ 74,906
Management Fees (see attached)	216,195
TOTAL (agree to Schedule V, line 17, col. 3)	$ 291,101
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 2,824
Frost, Ruttenberg & Rothblatt	Accounting	33,435
IIT / Sourcetech	Computer Consultant	645
Maxxsource	Computer Consultant	700
Alpha Data	Data Processing	6,322
JMS Service	Data Processing	1,275
Personnel Planners	Unemployment Consult	1,761
Crowe Chizek	Accounting	403
Urban Real Estate	Appraisal	3,000
American Express Tax Services	Tax Services	1,188
Daiwa	Audit Fee	831
Care Centers, Inc.	various (see attached)	350,118
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 402,502

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,784
Unemployment Compensation Insurance	41,467
FICA Taxes	287,258
Employee Health Insurance	182,205
Employee Meals	7,490
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	19,129
Pension Expense	1,801
Employee Physicals	25
Misc. Employee Welfare	4,665
Employee Drug Testing	4,357
TOTAL (agree to Schedule V, line 22, col.8)	$ 675,181

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,137
Health Care Worker Background Check	2,000
(Indicate # of checks performed 200)	
Advertising & Promotion	20,221
Dues & Subscriptions	5,295
Licenses & Fees	12,140
Allocation from Care Centers, Inc.	2,422
Less: Public Relations Expense	
Non-allowable advertising	(20,221)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,194

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,464
Allocation from Care Centers, Inc.	1,756
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,220

**See instructions.

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SOUTH SHORE NSG & REHAB CTR # 0042119 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $9715**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,172** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **131,400**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,490** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,324**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees